Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Clinical Neurophysiology Consultants 942 Wild Rose Ln. Brownsville, TX. 78520	MFDR Tracking #: M4-04-A958-01 D Injure Da
Respondent Name and Box #: EMPLOYERS INSURANCE CO. OF WAUSAU REP. BOX #28	Empl Insurance C

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATI

Requestor's Position Summary taken from the Table of Disputed Services: "Covered under TWCC spine treatment guidelines/Doesn't require pre-auth. under rule 134.600 (h) (8)"

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $1279.00
3. CMS 1500s
4. EOBs
5. Operative report
6. Intra-op SSEP report

Sent
AUG 05 2008
TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS'
COMPENSATION

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

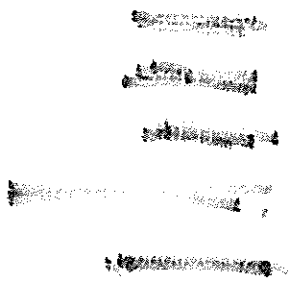
Respondent's Position Summary taken from the Table of Disputed Services: "Repeat Diag. testing over $350 requires preauthorization –Spine Treatment Guideline was repealed eff. 8-15-02."

Principle Documentation:

1. Response to DWC 60
2. EOB

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
12-23-03	95920 (x4 units) 95925 (x2 units) 95926 (x2 units) 95904 (x4 units)	A/X170	1 & 2	$0.00
Total Due:				$0.00



PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "A/X170" (pre-authorization was required, but not requested for this service per TWCC Rule 134.600).

2. Per a phone call between the Division and the Requestor on 7-8-08, these charges have now been paid to the Requestor's satisfaction. Additionally, the Respondent submitted the EOB that reflects payment was recommended. This file is not eligible for review by MDR due to payment recommendation being fulfilled. The Requestor opted not to withdraw this file.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section 413.011(a-d), Section 413.031 and Section 413.0311
28 Texas Administrative Code, Rules 134.1, 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

DECISION:

[redacted] — Authorized Signature

[redacted] — Medical Fee Dispute Resolution Officer

8/4/08 — Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.